Indiana State Department of Health

Division of Long Term Care

CHANGE OF OWNERSHIP APPLICATION
RESIDENTIAL

TO: Applicant

FROM: Program Director-Provider Services
Division of Long Term Care

This letter is to inform applicants of the required documentation for a change of ownership application for Residential facilities. For additional information on the rules and regulations involving this action please refer to:
http://www.in.gov/isdh/regsvcs/ltc/lawrules/index.htm

An application should include the following forms and/or documentation:

1. State Form 8200, Application For License To Operate A Health Facility, with required attachments (State Form 8200 enclosed);
2. State Form 19733, Implementing Indiana Code 16-28-2-6 (enclosed);
3. Documentation of the applicant entity's registration with the Indiana Secretary of State;
4. State Form 51996, Independent Verification Of Assets and Liabilities, with required documentation (State Form 51996 enclosed);
5. Completed State Form 4332, Bed Inventory (enclosed);
6. Facility floor plan on 8 ½" x 11" paper to show room numbers and number of beds per room;
7. Copy(s) of the Patient Transfer Agreement between the facility and local hospital(s);
8. A staffing plan that should include the number, educational level and personal health of employees;
9. Agreements/Contracts between the applicant entity with various providers of services for residents within the facility:
   a. Dietician;
   b. Emergency Shelter;
   c. Emergency Water Supply;
   d. Hospital Transfer Agreement(s) (if applicable, but not required);
   e. Pharmacy Services; and
   f. Pharmacy Consultant Services (if applicable).

   NOTE: Facilities with contracts for services which require a licensed and/or certified professional should include copies of the licenses and/or certification for the individuals who will be providing the services.

The following is a general outline of the application process:

1. The following documents must be submitted prior to the effective date for the change of ownership in order for the Division of Long Term Care to grant authorization for the new owner to occupy the facility:

    a. Completed State Form 8200, Application For License To Operate A Health Facility, with required attachments;

    b. Documentation of the applicant entity's registration with the Indiana Secretary of State;

    c. State Form 51996, Independent Verification Of Assets And Liabilities, with required attachments;

    d. Fully executed copy of the Bill of Sale, Lease, Asset Purchase Agreement, or other legal document for the change of ownership, which indicates the effective date for the change of ownership transaction;

    NOTE: Provided the Division of Long Term Care has been notified as to the date of the closing or lease signing, the fully executed legal document for the change of ownership transaction may be submitted to the Division via overnight delivery or facsimile immediately after the effective date (but must be received within seven (7) days of the effective date)

2. Upon receipt of these items, and upon the Division Director's satisfaction that the applicant entity meets the requirements of Indiana Code 16-28-2-1 *et seq*., the Director may grant authorization for the applicant entity to occupy the facility. The applicant entity has twenty-one (21) days after the authorization to operate the facility has been granted to submit the remainder of the application materials.

Under normal circumstances, a licensure survey for a change of ownership is not required.

Please do not hesitate to contact me at 317/233-7794 should you have questions regarding the application process.

Enclosures

Revised March 2005

APPLICATION FOR LICENSE TO OPERATE A HEALTH FACLITY

(Pursuant to IC 16-28 and 410 IAC 16.2)
State Form 8200 (R3/8-00)
Indiana State Department of Health-Division of Long Term Care

DIVISION OF LONG TERM CARE

Date Received_____
Date Approved_____
Approved by_____

Please Print or Type

SECTION I - TYPE OF APPLICATON

Application *(check appropriate item)*

☐ **Change of Ownership** ***(Anticipated date of Sale/Purchase/Lease)***_____ ☐ **New Facility** ☐ **Othe**r_____

SECTION II - IDENTIFYING INFORMATION

A. Practice Location (facility)

Name of Facility			
Street Address			P.O. Box:
City		County	Zip Code +4
Telephone Number ( )	Fax Number ( )	Facility's Cost Reporting Year From *(mm/dd):*	To *(mm/dd):*

B. Licensee/Ownership Information

Licensee *(Operator(s) of the facility)* The licensee and the applicant entity as described in Item IV-A of this application should be the same.

Street Address			P.O. Box
City		State	Zip Code+4
Telephone Number ( )	Fax Number ( )	EIN Number	Fiscal Year End Date *(mm/dd)*

C. Building Information

1. Status of building to be used *(check appropriate item)*

☐ Proposed New Construction ☐ Alteration of Existing Building ☐ Existing Licensed Health Facility ☐ Other_____

2. Type of Construction (materials) *(if new, as certified by architect or engineer registered in the state of Indiana)*

_____ _____ _____ _____

D. Type of Services to be Provided

1. Level of Care	Number of Beds in Each Category (to be licensed)	2. Certification Designation	Number of Beds in Each Category (to be licensed)
☐ Residential	_____	☐ SNF (Title 18 – Medicare)	_____
☐ Comprehensive (Certified)	_____	☐ SNF/NF (Title 18 – Medicare/Title 19 – Medicaid)	_____
☐ Comprehensive (Non-certified)	_____	☐ NF (Title 19 – Medicaid)	_____
☐ Children's Facility	_____	☐ ICF/MR	_____
☐ Developmentally Disabled	_____		
Total Number of Licensed Beds	_____	**Total Certified Beds**	_____

SECTION III – STAFFING

A. Administrator

Name *(enter full name)*

Indiana License Number *(please include a copy of license with application)*	Date of Birth	Date employed in this position

1. List post secondary education and health related experience

   _____

   _____

   _____

2. On a separate sheet, list the facilities in Indiana, or any other state, in which the Administrator has been previously employed, including the dates of employment and reason for leaving. Identify on this list any of these facilities which were operating with less than a full license at the time the Administrator was employed.

3. Has the administrator ever been convicted of any criminal offense related to a dependent population? ☐ Yes ☐ No
   (If yes, state on a separate sheet the facts of each case completely and concisely)

4. Has the administrator's license ever lapsed, been suspended or revoked? ☐ Yes ☐ No
   (If yes, state on a separate sheet the facts of each case completely and concisely)

5. Is the administrator presently in good health and physically able to fully carry out all of the duties in the operation of this health facility?
   ☐ Yes ☐ No *(If no, explain on a separate sheet)*

B. Director of Nursing

Name *(enter full name)*

Indiana License Number *(please include a copy of license with application)*	Date of birth	Date employed in this position

Education *(Name of School of Nursing)*

School Degree	Year Graduated

Other College Education

Qualifications or Experience

1. Has the Director of Nursing ever been convicted of any criminal offense related to a dependent population? ☐ Yes ☐ No
(If yes, state on a separate sheet the facts of each case completely and concisely)

2. Has the Director of Nurse's License ever lapsed, or ever been suspended or revoked? ☐ Yes ☐ No
(If yes, state on a separate sheet the facts of each case completely and concisely)

SECTON IV - DISCLOSURE OF OWNERSHIP AND CONTROLLING INTEREST STATEMENT
(In compliance with the Indiana Health Facilities Rules (410 IAC 16.2)

A. Applicant Entity

Name of Applicant Entity *(operator(s) of the facility)*

D/B/A *(Name of Facility)*

B. Ownership Information

List names and addresses of individuals or organizations having direct or indirect ownership interest of five percent (5%) or more in the applicant entity. Indirect ownership interest is interest in an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. *(use additional sheet if necessary)*

Name	Business Address	EIN Number

C. Type of Change of Ownership

☐ Assignment of Interest ☐ Lease ☐ Merger ☐ New Partnership
☐ Sale ☐ Sublease ☐ Termination of Lease ☐ Other_____

D. Type of Entity

For Profit	**NonProfit**	**Government**
☐ Individual	☐ Church Related	☐ State
☐ * Partnership	☐ Individual	☐ County
☐ ** Corporation	☐ * Partnership	☐ City
☐ *** Limited Liability Company	☐ ** Corporation	☐ City/County
☐ Other *(specify)* _____	☐ *** Limited Liability Company	☐ Hospital District
_____	☐ Other *(specify)* _____	☐ Federal
_____	_____	☐ Other *(specify)* _____

*If a Limited Partnership, submit a copy of the "Application For Registration" and "Certificate of Registration" signed by the Indiana Secretary of State.

**If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the Indiana Secretary of State. If a foreign Corporation, submit a copy of the "Certificate to do Business in the State of Indiana" signed by the Indiana Secretary of State.

***If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.

SECTION V - DISCLOSURE OF APPLICANT ENTITY

A. Officers/Directors/Members/Partners/Managers

1. **List all individuals (persons) associated with the applicant entity and indicate the individual's title (i.e. officer, director, member, partner, etc). If the applicant is a partnership, list the name and title of each partner or the name and title of all individuals associated with each entity that forms the partnership. If the applicant is a Limited Liability Company, list the name and title for all individuals associated with each member entity that forms the Limited Liability Company.** ***(use additional sheet if necessary)***

Name	Title	Business Address	Telephone Number

2. Are any individuals (persons) associated with the applicant entity (as listed in Sections IV.B and V.A.1) also associated with any other entity operating health facilities in Indiana or any other states? ☐ Yes ☐ No

If "yes," list names and addresses of facilities owned by each individual. (use *additional sheet if necessary)*

Facility Name	Address	City, County, State, Zip Code

3. Is the licensee (applicant) a lease entity? ☐ Yes ☐ No

   If yes, explain_____

   _____

   Please submit a copy of the lease showing an effective date. If this is a sublease or assignment of interest of a lease, submit a copy of all Leases affected by this transaction.

4. Is the applicant a subsidiary of another entity or corporation or does the applicant have subsidiaries under its control? ☐ Yes ☐ No
   (*If yes, list each entity (affiliated entity) on a separate sheet and explain the relationship)*

B. Licensure/Operating History

Are any of the individuals (as listed in Sections IV.B. and V.A.1.), associated with or have they been associated with, any other entity that is operating, or has operated, health facilities in Indiana or any other state, that:

1. Has/had a record of operation of less than a full license (i.e. three month probationary, provisional, etc)
   ☐ Yes ☐ No *(If "Yes", provide name of facility, state, date(s), restrictions and type)*

2. Had a facility's license revoked, suspended or denied. ☐ Yes ☐ No *(If "Yes", provide name of facility, state, type of actions and date(s))*

3. Was the subject of decertification, termination, or had a finding of patient abuse, mistreatment or neglect.
   ☐ Yes ☐ No *(If "Yes", provide name of facility, state, date, type of action, results of action)*

4. Had a survey finding of Substandard Quality of Care or Immediate Jeopardy ☐ Yes ☐ No *(If "Yes", provide all correspondence and deficiency reports, including the current or final resolution of the matter)*

5. Filed for bankruptcy, reorganization or receivership. ☐ Yes ☐ *No (If "Yes", include all relevant documentation and provide a detailed summary of the events and circumstances. Include state, dates and names of facilities)*

NOTE: If any of the answers above are "Yes", list each facility on a separate sheet of paper and explain the facts clearly and concisely.

SECTION VI - CERTIFICATION OF APPLICATION

I hereby certify that the operational policies of the health facility will not provide for discrimination based upon race, color. creed or national origin.

I swear or affirm that all statements made in this application and any attachments thereto are correct to the best of my knowledge and that the applicant entity will comply with all laws, rules and regulations governing the licensing of health facilities in Indiana.

Applicant's signature, as indicated in V-A of this application, or signature of applicant's agent should appear below.

IF SIGNED BY ANY INDIVIDUAL (EG., THE ADMINISTRATOR) OTHER THAN INDICATED IN SECTION V.A.1. OF THIS APPLICATION, AN AFFIDAVIT MUST BE SUBMITTED WITH THE APPLICATION AFFIRMING THAT SAID PERSON HAS BEEN GIVEN THE POWER TO BIND THE APPLICANT/LICENSEE.

Name of Authorized Representative *(Typed)*	Title
Signature	Date

STATE OF _____ COUNTY OF _____

Subscribed and sworn to before me, a Notary Public, for _____County, State of_____,

this _____day of _____20_____

(SEAL) (Signature)_____

_____, Notary Public
(Type or Print Name)

My Commission expires_____

IMPLEMENTING INDIANA CODE 16-28-2-6

State Form 19733 (R4/11-00)
Indiana State Department of Health-Division of Long Term Care

PLEASE READ BEFORE COMPLETING THIS FORM

IC 16-28-2-6 created a reporting requirement for some facilities which charge certain fees and have a name which implies association with a religious, charitable, or other nonprofit organization.

This form was developed and approved by the Indiana Health Facilities Council in order to obtain the information required by law. Please read the attached form carefully. If your facility is **not** one of those included in the category affected by this law, you need only check the appropriate box in Section A, have the form notarized, signed by the appropriate person, and return it with your application.

If you **are** included in the category affected, read and follow the directions, have the form notarized, signed by the appropriate person and return it with your application.

The information required on this form is necessary in order for a health facility to be licensed.

Name of Facility

Street Address

City	State	Zip+4

SECTION A

This health facility ρ does ρ does not have charges other than daily or monthly rates for room, board, and care consisting of a required admission payment of money or investment of money or other consideration for admission.

IF SECTION A ABOVE IS ANSWERED IN THE NEGATIVE, SKIP TO SECTION F BELOW

SECTION B

The name of this health facility or the name of the person operating the health facility ρ does ρ does not imply affiliation with a religious, charitable, or other nonprofit organization.

SECTION C

Is this health facility affiliated with a religious, charitable, or other nonprofit organization? ρ yes ρ no

SECTION D

If Section C was answered "yes", list the nature and extent of such affiliation, including the name of such affiliated organization, its address, and the extent, if any, to which it is responsible for the financial and contractual obligations of the health facility. (This material, if lengthy, may be submitted as an attachment. Attachments must be numbered and referenced on lines provided below.)

_____

_____

_____

_____

_____

_____

SECTION E

Unless Sections B and C above are answered in the negative, complete this Section, and **NOTE THE OBLIGATIONS OF HEALTH FACILITY**

1. The health facility hereby agrees that all health facility's advertisements and solicitations shall include a summary statement disclosing any affiliation between the health facility and the religious, charitable, or other nonprofit organization; and the extent, if any, to which the affiliated organizations is responsible for the financial and contractual obligations of the health facility. **Please attach the summary statement.** If not attached, explain why not, and if, an when, it will be furnished.

2. The health facility shall furnish each prospective resident with a disclosure statement as contemplated by Indiana law. **Please attach the disclosure statement.** If not attached, explain why not, and if, and when, it will be furnished.

_____

_____

SECTION F

THE HEALTH FACILITY HEREBY AGREES THAT, WHENEVER THERE IS A CHANGE IN ITS ACTUAL OR IMPLIED AFFILIATION WITH A RELIGIOUS, CHARITABLE OR NONPROFIT ORGANIZATION, AND THE FACILTIY HAS ADMISSION CHARGES OTHE THAN DAILY OR MONTLY RATES FOR ROOM, BOARD, AND CARE, THEN THE FACILITY WILL PREPARE OR AMEND A SUMMARY STATEMENT, AND THE DISCLOSURE STATEMENT, IF THAT IS NECESSARY UNDER THE PROVISIONS OF INDIANA CODE 16-28-2-6, AND IMMEDIATELY FILE SUCH PREPARED STATEMENT(S) WITH THE INDIANA HEALTH FACILITIES COUNCIL.

I affirm, under the penalties of perjury, that the information and undertakings set out above are made in good faith, true, and complete, to the best of my knowledge and belief, and that the person signing the foregoing form is the duly authorize representative of the health facility for that purpose.

_____
Board Chairman or Owner

_____
Print Name of Signer

STATE OF _____)

COUNTY OF_____)

Subscribed and sworn to before me, this_____day of _____,20_____

_____
Notary Public

(Seal)

_____
County of Residence

My commission expires_____

PLEASE RETURN FORM TO:

Indiana State Department of Health
Division of Long Term Care
2 North Meridian Street, Section 4-B
Indianapolis, IN 46204

INDEPENDENT VERIFICATION
OF ASSETS AND LIABILITIES
State Form 51996 (R1/6-05)
Indiana State Department of Health-Division of Long Term Care
(Pursuant to IC 16-28, IAC 16.2-3.1-2 and 410 IAC 16.2-5-1.1)

INSTRUCTIONS:

Licensee:	CPA:
1. Complete sections I, II, and section III, F and G. 2. Attach any documentation used to complete the information. Include the method used to determine projection of revenue and operating expenses, in order to complete the application process. 3. Forward the completed materials to a Certified Public Accountant. 4. Upon return from the CPA, sign and date the certification statement in section V (Licensee) and include the entire set of documents with the completed application.	1. Complete sections III, A, B, C, D, and E by A. using an audit, review, or compilation completed within the preceding twelve months, or B. performing a financial compilation. 2. Using agreed upon procedures; verify items in section IV, F. 3. Sign and date the certification statement as indicated in Section IV (CPA). 4. Attach the compilation and agreed upon procedures report to this form and return to the Licensee.

Please Type or Print Legibly

SECTION I – TYPE OF APPLICATON

Application *(check appropriate item)*

☐ **Change of Ownership (*Anticipated date of Sale/Purchase/Lease:_____*)** ☐ **New Facility** ☐ **Other** _____

SECTION II - IDENTIFYING INFORMATION

A. Physical Location (facility)

Name of Facility:			
Street Address			
City		County	Zip Code +4
Telephone Number ( )	Fax Number ( )	Facility's Cost Reporting Year From (mm/dd)	To (mm/dd):

B. Licensee/Ownership Information

Licensee (Operator(s) of the facility) Same as Licensee on Application for License to Operate a Health Facility, Section B			
Street Address			P.O. Box
City	State	Zip Code + 4	

SECTION III – SELECTED BALANCE SHEET ITEMS AS OF_____
(date)

A. Current Assets:		**B. Current Liabilities:**	
Asset	***Amount (rounded to nearest dollar)***	***Liability***	***Amount (rounded to nearest dollar)***
Cash		Accounts Payable	
Accounts Receivable		Other Current Liabilities	
Less: Allowance for bad debt		Intercompany Liabilities	
Prepaid Expenses		Non-related Party Working Capital Loans	
Inventories and Supplies		Related Party Working Capital	
Intercompany Receivables		Other Current Liabilities	
All Loans to Owners, Officers & Related Parties		**Total Current Liabilities**	
Assets Held for Investment			
Other Current Assets			
Total Current Assets			

C. Working Capital: (Total Current Assets minus Total Current Liabilities) $_____

D. Total Liabilities: $_____ **E. Total Owner's Equity or Fund Balance: $ _____**

F. Lines of Credit *(List all letters of credit or other open lines of credit available, attach additional sheet(s) if necessary)***:**

Name of Institution or Lender	**Amount of Credit Available**
1.	$
2.	$
3.	$
4.	$

G. Number of Facility Beds: _____

Projected Monthly Revenue: **$**_____

Projected Monthly Operating Expenses: **$**_____

SECTION IV – CERTIFICATION STATEMENTS

Under penalty of perjury: I certify that the foregoing information, including any attached exhibits, schedules, and explanations is true, accurate, and complete. Having reviewed each section, together with the identified attachments, I am satisfied that each section is correctly answered and that the answers and any attachments are sufficient in scope and clarity to accomplish full disclosure (full disclosure requires that a knowledgeable financial reader, after reviewing the explanations and attachments, would not be misled). I understand that any false claims, statements, or documents, or concealment of material fact may be prosecuted under applicable federal or state law.

Name of Authorized Person (*Typed*)	**Title/Position**
Signature of Authorized Person	**Date**

This is to confirm that I (we) have prepared a compilation of financial information which is the basis for the data indicated in sections A through E inclusive, and have verified the existence of the lines of credit listed in section F, pursuant to agreed upon procedures between myself (us) and the licensee(s) listed herein (see attached compilation and agreed upon procedures report).

Name of Certified Public Accountant representing the firm (*Typed*)	**Title/Position**	
Signature of Certified Public Accountant representing the firm	**License/Certification Number**	**Date**

BED INVENTORY
State Form 4332 (R8/1-02)
Indiana State Department of Health-Division of Long Term Care

Name of Facility		
Street Address		
City	County	Zip+4

PLEASE SPECIFY THE NUMBER OF BEDS IN EACH ROOM AS FOLLOWS:
Each room should be listed only once and listed in numerical order under each classification column.

Title 18 SNF = Medicare ONLY beds **NCC = Non-Certified Comprehensive**
Title 18 SNF/NF 19 NF = Medicare/Medicaid (Dually Certified) **Residential Level of Care**
Title 19 NF = Medicaid

All licensed beds must be listed.

Room No.	**No. Beds**
8	2
9	2
10	2
11	3
12	2
20	2

Title 18 SNF		**Title 18/19 SNF/NF**		**Title 19 NF**				**NCC**		**Residential**	
Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds
Total 18 SNF		Total 18/19 SNF/NF				Total 19 NF		Total NCC		Total Residential	

Current SNF Census _____

Current SNF/NF Census _____

Current NF Census _____

Current NCC Census _____

Current Residential Census _____

TOTAL CURRENT CENSUS _____

TOTAL LICENSED CAPACITY _____

NOTE

Completion of this form is not an official bed change request or a change from those beds classifications and numbers currently licensed

Completed by	Position	Date